Form F

CHARITABLE HEALTH CARE PROVIDER PROGRAM

An Agreement between
a Charitable Health Care Provider and
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Office of Local and Rural Health

To Provide Gratuitous Services

Name_____, _____ _____
Last First MI

Date Of Birth: _____/_____/_____

Address_____
Street Address

_____
City State Zip

Daytime Phone_____ FAX_____

Profession (MD, RN, DDS,etc.): _____

License or Registration Number: _____

My signature on this agreement constitutes my intention to gratuitously provide care to medically indigent patients which may include patients covered by medical assistance programs operated by the Kansas Department of Social and Rehabilitation Services (SRS), (including Medicaid, HealthWave and MediKan) when those patients are seen pursuant to the terms of the Charitable Health Care Provider Program. I understand that in order to be considered gratuitous, no charges may be levied nor claims submitted to SRS for payment. However, nothing in this agreement shall be construed to waive my right to bill SRS for services provided to persons covered by medical assistance programs operated by SRS when such patients are not seen on a gratuitous basis as part of the Charitable Health Care Provider Program.

Further, I understand that if I choose to provide services gratuitously to patients who are not referred through a Point of Entry, it is my responsibility to ensure that patient eligibility records are maintained and periodic statistical reports submitted to the Charitable Health Care Provider Program.

_____ _____
Signature of Applicant Date